Medical History Questionnaire

Appendix G

Original, April 2000

Environmental Protection Agency

Lake Guardian

Survey Personnel Data Sheet

Date: _____

This form has been designed to obtain information necessary in the event of an emergency while preserving an individual's privacy. In the interest of your personal safety and well being, it is vital that someone aboard be aware of any significant medical condition that you may have, which may require the knowledgeable action of someone on-board to assist you. All information provided will be kept confidential. Thank you for your cooperation.

Name	
Phone Number	
Home Address	
Mailing Address	
Z or License Rating	
License Held	
No.	
SS#	
Date of Birth	
Place of Birth	
Blood Type	
Medical Alert Tag? (Y/N)	
Last Tetanus Shot	
Physician's Name	
Phone Number	
Date and Place of Last Physical Exam	
Height	
Weight	

Eye Color	
Hair Color	
Contact Lenses (Y/N)	
Scars or Marks	
In Case of an Emergency, Notify:	
Name	
Relationship	
Address	
Phone Number	

Please circle appropriate response(s) and comment.

Do you have known heart disease, attack or stroke: by-pass surgery or other type of heart surgery?
Do you have insulin or noninsulin dependent diabetes?
Do you have high blood pressure? Your typical blood pressure reading?
Do you have allergies? (Specify)
Do you have any current history of thyroid, kidney, liver, lung diseases, seizures, cancer, pregnancy, bleeding, etc.?
Do you currently have any of the following: chest pain or pressure, shortness of breath, irregular heart beat, dizziness, other?
Do you have any problems with bones, muscle, back, neck?

Current medication(s) and dosage?

Medical History

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Please check the appropriate responses for any of the following medical conditions you currently have or have had in the past (specify).

Cardiovascular			
Condition	**Yes**	**No**	**Comments**
High Blood Pressure			
Heart Attack			
Coronary Artery Disease			
Mitral Valve Prolapsed			
Heart Murmur			
Stroke			
Aneurysm			
Coronary bypass or any other type of heart surgery			
Other Cardiovascular Disease, Specify			
Respiratory			
Condition	**Yes**	**No**	**Comments**
Asthma			
Emphysema			
Bronchitis			
Tuberculosis			
Collapsed Lung			
Lung Surgery			
Other Lung Disease, Specify			

Neurological			
Condition	**Yes**	**No**	**Comments**
Migraine Headaches			
Seizures			
Head Injury			
Spinal Cord Injury			
Head/Spine Surgery			
Other Neurological Disease, Specify			
Musculoskeletal			
Condition	**Yes**	**No**	**Comments**
Gait Abnormalities			
Loss of function of extremity			
Back/Neck Pain			
Other, specify			
Other Significant Medical Conditions			
Condition	**Yes**	**No**	**Comments**
Bleeding disorder			
Cancer History			
Claustrophobia			
Diabetes (specify insulin or non-insulin dependent)			
Hepatitis/Liver Disease			
Kidney Disease			
Psychiatric Disease			
Thyroid Disease			
Pregnancy			
Other, specify			

Please indicate if you have any of the following signs or symptoms:

Condition	Yes	No	Comments
Fever			
Generalized weakness			
Unexplained weight loss/gain			
Change in vision			
Nosebleeds			
Difficulty hearing			
Chest pain or pressure			
Irregular heart beat			
Palpitations			
Cough			
Wheezing			
Shortness of breath			
Nausea/vomiting			
Rectal bleeding or black tarry stools			
Dizziness			
Loss of consciousness			
Panic attacks			
Numbness or tingling			
Other, specify			